| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155218 | A. BUILDING _____ B. WING _____ | 03/29/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| REGENCY PLACE OF DYER | 2300 GREAT LAKES DRIVE DYER, IN46311 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F0000 | This visit was for a Post Survey Revisit (PSR) to the the Investigation of Complaint IN00085845 completed on 3/3/11<br><br>This visit was in conjunction with a Post Survey Revisit (PSR) to to the PSR (3/3/11) to Complaint IN00083771 investigated on 12/28/10.<br><br>Complaint IN00085845 not corrected.<br><br>Survey dates: March 28 and 29, 2011<br><br>Facility number: 000123<br>Provider number: 155218<br>AIM number: 100266720<br><br>Survey team:<br>Janelyn Kulik, RN, TC<br>Regina Sanders, RN<br>Sheila Sizemore, RN<br>(March 28, 2011)<br>Marcia Mital, RN<br>(March 28, 2011)<br>Kelly Sizemore, RN<br>(March 28, 2011)<br><br>Census bed type:<br>SNF/NF: 153<br>Total: 153<br><br>Census payor type: | F0000 | The facility requests that this plan of correction be considered its credible allegations of compliance.<br><br>Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusions set forth in this allegation by the survey agency.<br><br>Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to participate in the Title 18 and | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | Medicare: 36<br>Medicaid: 93<br>Other: 24<br>Total: 153<br><br>Sample: 11<br><br>These deficiencies also reflect State findings in accordance with 410 IAC 16.2.<br><br>Quality review completed 4-4-11<br>Cathy Emswiller RN | | Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by the facility. | |

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| F0224 SS=D | Based on observation, interview, and record review, the facility failed to ensure a resident's care was not neglected related to leaving a resident lying in incontinent bowel movement for a long period of time, for 1 of 10 residents who require assistance with toileting in a sample of 11. (Resident #E)<br><br>Findings include:<br><br>A facility policy, dated 10/09, titled, "Abuse", received as current from the Administrator, indicated, "...neglect...strictly prohibited...Develop a specific resident care plan and/or care card that identify resident care needs to reduce the risk of being abused and neglected..."<br><br>A facility policy, dated 10/08, titled, Federal Abuse, Neglect and Exploitation Definitions", received as current from the Administrator, indicated, "...Neglect, Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness..."<br><br>During an interview on 03/28/11 at 11:42 a.m., Resident #E indicated she had been waiting an hour to have her brief changed. She indicated CNA #1 came in | F0224 | It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done:<br><br>The corrective action taken for the residents found to have been affected by the deficient practice was:<br><br>**Peri care was provided to the Res. E. Resident was interviewed and stated she waited approximately 1 hour for staff to provide care. Staff involved have been counseled and educated on promptly responding to resident needs.**<br><br>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:<br><br>**Interviewable residents were asked if they had any issues related to timeliness of care and rounds on non-interviewable residents were also made. No other issues were identified through this process.**<br><br>The measures put into place and systemic change made to ensure the deficient practice does not recur is: | 04/11/2011 |

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| | and answered her call light and she told the CNA she had been incontinent. She indicated CNA #1 turned off the call light and told her she was busy with another resident and another CNA had been assigned to the Resident. She indicated she would tell the Nurse. Resident #E indicated LPN #3 came into the room and she informed the LPN she had been incontinent of bowel movement and the LPN told her she would tell the CNA assigned to her.<br><br>During an interview on 03/28/11 at 11:45 a.m., LPN #3 indicated the resident had told her she had been incontinent of bowel movement. LPN #3 indicated she had not informed the Resident's CNA because the CNA was on break. She indicated she would go tell the CNA now.<br><br>During an interview on 03/28/11 at 11:50 a.m., CNA #2 indicated she was assigned to Resident #E. She indicated she had returned from a 30 minute lunch break at 11:20 a.m. She indicated she was just informed the resident needed some help.<br><br>During an observation on 03/28/11 at 11:53 a.m., CNA #2 entered Resident #E's room to provide incontinence care to the resident. The Resident was observed to have been incontinent of soft bowel | | **Care staff has been educated by the DNS and ED related to timely call light response and provision of care at the time of need. Random call light audits are conducted by department managers to ensure timely response. Department managers are conducting daily interview with residents to ensure resident needs are being met.**<br><br>To ensure the deficient practice does not recur, the monitoring system established is:<br><br>**A Performance Improvement tool has been developed that evaluates timely provision of care. DNS or Designee will complete PI tool weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI committee for further review until 100% compliance is achieved.** | |

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| | movement. The bowel movement had dried on the resident's buttocks. Upon interviewing the CNA #2 during the observation, she indicated part of the bowel movement had dried on the resident's skin. CNA #2 then washed the area several times to remove the dried bowel movement. The resident's buttocks was red and excoriated and there was a superficial open area on the posterior left thigh which was approximately the size of a dime, round in shape and the skin around the open area was pink. During an interview at the time of the observation, CNA #2 indicated the skin was red and excoriated on the Resident's buttocks. She indicated the area on the left posterior thigh was opened.<br><br>During an interview on 03/28/11 after the incontinence care had been completed, the Resident indicated she was uncomfortable laying in the bowel movement.<br><br>During an interview on 03/28/11 at 12:05 p.m., LPN #3 indicated the Resident had told her about being incontinent of bowel movement around 11:20 a.m. or 11:30 a.m. She indicated the other CNA's on the unit were all busy and she was on the phone with a family member so she could not take care of resident when she requested help. | | | |

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During an interview on 03/28/11 at 12:15 p.m., CNA #1 indicated the resident had told her she had been incontinent of bowel movement. She indicated she was getting ready to give another resident a shower, but answered Resident #E's call light. She indicated she had turned the call light off and left the room and told the nurse the resident had been incontinent and needed help. She indicated she did not remember what time she answered the resident's call light.

Resident #E's record was reviewed on 03/28/11 at 12:10 p.m. The Resident's diagnoses included, but were not limited to, hypertension and osteoarthritis.

The Resident's Physician's Recapitulation Orders, dated 03/11, indicated the Resident was capable of making her own health decisions.

The Annual Minimum Data Set Assessment, dated 01/18/11, indicated the resident was cognitively intact with a score of 15, required extensive assistance for toileting, bed mobility, and personal hygiene, and was frequently incontinent of bowel (two or more episodes).

The most current, "Weekly Skin Check

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| | Sheet", 03/15/11, indicated the resident had no new skin conditions.<br><br>The Resident's, "Weekly Non-pressure Skin Condition Report", dated 03/17/11, indicated the resident had a fungal rash to the bilateral thighs, which was resolved on 03/17/11.<br><br>The Nurses' Notes, dated 03/13/11 at 8 a.m. through 03/25/11 12 a.m., lacked documentation to indicate the resident had a red and excoriated buttocks.<br><br>During an interview on 03/28/11 at 1:05 p.m., LPN #3 indicated if the resident had skin concerns, it would be documented in the Nurses' Notes.<br><br>This deficiency was cited 03/03/11. The Facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>This Federal tag relates to complaint IN00085845.<br><br>3.1-27(a)(3)<br>3.1-28(a) | | | |

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| F0224 SS=D | | F0224 | It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done:<br><br>The corrective action taken for the residents found to have been affected by the deficient practice was:<br><br>**Peri care was provided to the Res. E. Resident was interviewed and stated she waited approximately 1 hour for staff to provide care. Staff involved have been counseled and educated on promptly responding to resident needs.**<br><br>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:<br><br>**Interviewable residents were asked if they had any issues related to timeliness of care and rounds on non-interviewable residents were also made. No other issues were identified through this process.**<br><br>The measures put into place and systemic change made to ensure the deficient practice does not recur is: | 04/11/2011 |

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| | | | **Care staff has been educated by the DNS and ED related to timely call light response and provision of care at the time of need. Random call light audits are conducted by department managers to ensure timely response. Department managers are conducting daily interview with residents to ensure resident needs are being met.**<br><br>To ensure the deficient practice does not recur, the monitoring system established is:<br><br>**A Performance Improvement tool has been developed that evaluates timely provision of care. DNS or Designee will complete PI tool weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI committee for further review until 100% compliance is achieved.** | |

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| F0226 SS=D | | F0226 | It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done:<br><br>The corrective action taken for the residents found to have been affected by the deficient practice was:<br><br>**Peri care was provided to the Res. E. Resident was interviewed and stated she waited approximately 1 hour for staff to provide care. Staff involved have been counseled and educated on promptly responding to resident needs.**<br><br>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:<br><br>**Interviewable residents were asked if they had any issues related to timeliness of care and rounds on non-interviewable residents were also made. No other issues were identified through this process.**<br><br>The measures put into place and systemic change made to ensure the deficient practice does not recur is: | 04/11/2011 |

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| F0226 SS=D | | F0226 | It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done:<br><br>The corrective action taken for the residents found to have been affected by the deficient practice was:<br><br>**Peri care was provided to the Res. E. Resident was interviewed and stated she waited approximately 1 hour for staff to provide care. Staff involved have been counseled and educated on promptly responding to resident needs.**<br><br>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:<br><br>**Interviewable residents were asked if they had any issues related to timeliness of care and rounds on non-interviewable residents were also made. No other issues were identified through this process.**<br><br>The measures put into place and systemic change made to ensure the deficient practice does not recur is: | 04/11/2011 |

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| F0226 SS=D | Based on observation, record review and interview, the facility failed to ensure their Abuse policy was followed as written related to leaving a resident lying in incontinent bowel movement for a long period of time, for 1 of 10 residents who require assistance with toileting in a sample of 11. (Resident #E)<br><br>Findings include:<br><br>A facility policy, dated 10/09, titled, "Abuse", received as current from the Administrator, indicated, "...neglect...strictly prohibited...Develop a specific resident care plan and/or care card that identify resident care needs to reduce the risk of being abused and neglected..."<br><br>A facility policy, dated 10/08, titled, Federal Abuse, Neglect and Exploitation Definitions", received as current from the Administrator, indicated, "...Neglect, Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness..."<br><br>During an interview on 03/28/11 at 11:42 a.m., Resident #E indicated she had been waiting an hour to have her brief changed. She indicated CNA #1 came in and answered her call light and she told | F0226 | It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done:<br><br>The corrective action taken for the residents found to have been affected by the deficient practice was:<br><br>**Peri care was provided to the Res. E. Resident was interviewed and stated she waited approximately 1 hour for staff to provide care. Staff involved have been counseled and educated on promptly responding to resident needs.**<br><br>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:<br><br>**Interviewable residents were asked if they had any issues related to timeliness of care and rounds on non-interviewable residents were also made. No other issues were identified through this process.**<br><br>The measures put into place and systemic change made to ensure the deficient practice does not recur is: | 04/11/2011 |

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| REGENCY PLACE OF DYER | 2300 GREAT LAKES DRIVE DYER, IN46311 |

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| | the CNA she had been incontinent. She indicated CNA #1 turned off the call light and told her she was busy with another resident and another CNA had been assigned to the Resident. She indicated she would tell the Nurse. Resident #E indicated LPN #3 came into the room and she informed the LPN she had been incontinent of bowel movement and the LPN told her she would tell the CNA assigned to her.<br><br>During an interview on 03/28/11 at 11:45 a.m., LPN #3 indicated the resident had told her she had been incontinent of bowel movement. LPN #3 indicated she had not informed the Resident's CNA because the CNA was on break. She indicated she would go tell the CNA now.<br><br>During an interview on 03/28/11 at 11:50 a.m., CNA #2 indicated she was assigned to Resident #E. She indicated she had returned from a 30 minute lunch break at 11:20 a.m. She indicated she was just informed the resident needed some help.<br><br>During an observation on 03/28/11 at 11:53 a.m., CNA #2 entered Resident #E's room to provide incontinence care to the resident. The Resident was observed to have been incontinent of soft bowel movement. The bowel movement had | | **Care staff has been educated by the DNS and ED related to timely call light response and provision of care at the time of need. Random call light audits are conducted by department managers to ensure timely response. Department managers are conducting daily interview with residents to ensure resident needs are being met.**<br><br>To ensure the deficient practice does not recur, the monitoring system established is:<br><br>**A Performance Improvement tool has been developed that evaluates timely provision of care. DNS or Designee will complete PI tool weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI committee for further review until 100% compliance is achieved.** | |

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| | 155218 | A. BUILDING _____ B. WING _____ | 03/29/2011 |

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| | dried on the resident's buttocks. Upon interviewing the CNA #2 during the observation, she indicated part of the bowel movement had dried on the resident's skin. CNA #2 then washed the area several times to remove the dried bowel movement. The resident's buttocks was red and excoriated and there was a superficial open area on the posterior left thigh which was approximately the size of a dime, round in shape and the skin around the open area was pink. During an interview at the time of the observation, CNA #2 indicated the skin was red and excoriated on the Resident's buttocks. She indicated the area on the left posterior thigh was opened.<br><br>During an interview on 03/28/11 after the incontinence care had been completed, the Resident indicated she was uncomfortable laying in the bowel movement.<br><br>During an interview on 03/28/11 at 12:05 p.m., LPN #3 indicated the Resident had told her about being incontinent of bowel movement around 11:20 a.m. or 11:30 a.m. She indicated the other CNA's on the unit were all busy and she was on the phone with a family member so she could not take care of resident when she requested help. | | | |

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| | During an interview on 03/28/11 at 12:15 p.m., CNA #1 indicated the resident had told her she had been incontinent of bowel movement. She indicated she was getting ready to give another resident a shower, but answered Resident #E's call light. She indicated she had turned the call light off and left the room and told the nurse the resident had been incontinent and needed help. She indicated she did not remember what time she answered the resident's call light.<br><br>Resident #E's record was reviewed on 03/28/11 at 12:10 p.m. The Resident's diagnoses included, but were not limited to, hypertension and osteoarthritis.<br><br>The Resident's Physician's Recapitulation Orders, dated 03/11, indicated the Resident was capable of making her own health decisions.<br><br>The Annual Minimum Data Set Assessment, dated 01/18/11, indicated the resident was cognitively intact with a score of 15, required extensive assistance for toileting, bed mobility, and personal hygiene, and was frequently incontinent of bowel (two or more episodes).<br><br>The most current, "Weekly Skin Check Sheet", 03/15/11, indicated the resident | | | |

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| | had no new skin conditions.<br><br>The Resident's, "Weekly Non-pressure Skin Condition Report", dated 03/17/11, indicated the resident had a fungal rash to the bilateral thighs, which was resolved on 03/17/11.<br><br>The Nurses' Notes, dated 03/13/11 at 8 a.m. through 03/25/11 12 a.m., lacked documentation to indicate the resident had a red and excoriated buttocks.<br><br>During an interview on 03/28/11 at 1:05 p.m., LPN #3 indicated if the resident had skin concerns, it would be documented in the Nurses' Notes.<br><br>This deficiency was cited 03/03/11. The Facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>This Federal tag relates to complaint IN00085845.<br><br>3.1-28(a) | | | |

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| F0282 SS=D | Based on observation, record review, and interview, the facility failed to ensure physician's orders and resident's plans of care were followed, related to incontinence products, incontinence care, medications, and catheter care for 2 of 11 residents reviewed for following physician's orders and plans of care in a sample of 11. (Residents #E and #F)<br><br>Findings include:<br><br>1. Resident #E's record was reviewed on 03/28/11 at 12:10 p.m. The Resident's diagnoses included, but were not limited to, hypertension and osteoarthritis.<br><br>A) A care plan, dated 03/24/11, indicated the resident was at risk for impaired skin integrity. The approaches indicated, "1. Keep skin clean & (and) dry..."<br><br>During an interview on 03/28/11 at 11:42 a.m., Resident #E indicated she had been waiting an hour to have her brief changed. She indicated CNA #1 came in and answered her call light and she told the CNA she had been incontinent. She indicated CNA #1 turned off the call light and told her she was busy with another resident and another CNA had been assigned to the Resident. She indicated | F0282 | It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done:<br><br>The corrective action taken for the residents found to have been affected by the deficient practice was:<br><br>**Res. E has been provided with cloth briefs. Res. F's Ferrouse Sulfate was restarted on 3/28/11. Peri care was provided to Res. E. Resident was interviewed and stated she waited approximately 1 hour for staff to provide care. Staff involved have been counseled and educated on promptly responding to resident needs.**<br><br>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:<br>**Residents with an order for cloth briefs have been observed to ensure they are using cloth briefs. Full facility review of all Medication Records was completed to ensure that there were no other transcription errors. Interviewable residents were asked if they had any issues related to timeliness of care and rounds on non-interviewable residents were also made. No other issues were identified** | 04/11/2011 |

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| | she would tell the Nurse. Resident #E indicated LPN #3 came into the room and she informed the LPN she had been incontinent of bowel movement and the LPN told her she would tell the CNA assigned to her.<br><br>During an interview on 03/28/11 at 11:45 a.m., LPN #3 indicated the resident had told her she had been incontinent of bowel movement. LPN #3 indicated she had not informed the Resident's CNA because the CNA was on break. She indicated she would go tell the CNA now.<br><br>During an interview on 03/28/11 at 11:50 a.m., CNA #2 indicated she was assigned to Resident #E. She indicated she had returned from a 30 minute lunch break at 11:20 a.m. She indicated she was just informed the resident needed some help.<br><br>During an observation on 03/28/11 at 11:53 a.m., CNA #2 entered Resident #E's room to provide incontinence care to the resident. The Resident was observed to have been incontinent of soft bowel movement. The bowel movement had dried on the resident's buttocks. Upon interview of CNA #2 during the observation, she indicated part of the bowel movement had dried on the resident's skin. CNA #2 then washed the | | **through this process.**<br><br>The measures put into place and systemic change made to ensure the deficient practice does not recur is:<br><br>**Nursing staff was educated by the DNS on using cloth briefs when ordered and following the plan of care. Licensed staff have been educated by the DNS on correctly transcribing orders to the resident medication administration record. Nursing staff has been educated by the DNS and ED related to timely call light response and provision of care at the time of need.**<br><br>To ensure the deficient practice does not recur, the monitoring system established is:<br><br>**A Performance Improvement tool has been developed that will monitor residents for the proper use of cloth briefs according to the plan of care. An additional Performance Improvement indicator has been established which evaluates compliance with transcribing physician orders** | |

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| | area several times to remove the dried bowel movement. The resident's buttocks was red and excoriated and there was a superficial open area on the posterior left thigh was approximately the size of a dime, round in shape and the skin around the open area was pink. During an interview at the time of the observation, CNA #2 indicated the skin was red and excoriated on the Resident's buttocks. She indicated the area on the left posterior thigh was opened.<br><br>During an interview on 03/28/11 at 12:05 p.m., LPN #3 indicated the Resident had told her about being incontinent of bowel movement around 11:20 a.m. or 11:30 a.m. She indicated the other CNA's on the unit were all busy and she was on the phone with a family member so she could not take care of resident when she requested help.<br><br>During an interview on 03/28/11 at 12:15 p.m., CNA #1 indicated the resident had told her she had been incontinent of bowel movement. She indicated she was getting ready to give another resident a shower, but answered Resident #E's call light. She indicated she had turned the call light off and left the room and told the nurse the resident had been incontinent and needed help. She indicated she did not remember | | **to the resident medication administration record. The DNS or Designee will complete PI tools weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI committee for further review until 100% compliance is achieved. A Performance Improvement tool has been developed that evaluates timely provision of care. DNS or Designee will complete PI tool weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI committee for further review until 100% compliance is achieved.** | |

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| | what time she answered the resident's call light.<br><br>B) The Resident's Physician's Recapitulation Orders, dated 03/11, indicated an order for cloth briefs.<br><br>During an observation on 03/28/11 at 11:53 a.m., CNA #2 performed incontinence care on the resident. The CNA removed a disposable, non-cloth brief and replaced the brief with a disposable, non-cloth brief.<br><br>During an interview on 03/28/11 at 1:15 p.m., LPN #3 indicated the resident did not have cloth brief on. | | | |

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| F0282 SS=D | | F0282 | It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done:<br><br>The corrective action taken for the residents found to have been affected by the deficient practice was:<br><br>**Res. E has been provided with cloth briefs. Res. F's Ferrouse Sulfate was restarted on 3/28/11. Peri care was provided to Res. E. Resident was interviewed and stated she waited approximately 1 hour for staff to provide care. Staff involved have been counseled and educated on promptly responding to resident needs.**<br><br>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:<br>**Residents with an order for cloth briefs have been observed to ensure they are using cloth briefs. Full facility review of all Medication Records was completed to ensure that there were no other transcription errors. Interviewable residents were asked if they had any issues related to timeliness of care and rounds on non-interviewable residents were also made. No other issues were identified** | 04/11/2011 |

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| | | | **through this process.**<br><br>The measures put into place and systemic change made to ensure the deficient practice does not recur is:<br><br>**Nursing staff was educated by the DNS on using cloth briefs when ordered and following the plan of care. Licensed staff have been educated by the DNS on correctly transcribing orders to the resident medication administration record. Nursing staff has been educated by the DNS and ED related to timely call light response and provision of care at the time of need.**<br><br>To ensure the deficient practice does not recur, the monitoring system established is:<br><br>**A Performance Improvement tool has been developed that will monitor residents for the proper use of cloth briefs according to the plan of care. An additional Performance Improvement indicator has been established which evaluates compliance with transcribing physician orders** | |

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| | | | **to the resident medication administration record. The DNS or Designee will complete PI tools weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI committee for further review until 100% compliance is achieved. A Performance Improvement tool has been developed that evaluates timely provision of care. DNS or Designee will complete PI tool weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI committee for further review until 100% compliance is achieved.** | |

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| F0282 SS=D | 2. Resident #F's record was reviewed on 3/28/11 at 11:50 a.m. Resident #F's diagnoses included, but were not limited to, urinary tract infection, congestive heart failure, anemia, and arthritis.<br><br>A) During the initial tour on 3/28/11 at 10:15 a.m., with the SDC (Staff Development Coordinator) present, Resident #F was observed sitting in her wheelchair in her room. The resident's indwelling catheter tubing was on the floor under the wheelchair. The SDC applied gloves and adjusted the catheter tubing so it was not touching the floor. The SDC indicated the resident had a history of urinary tract infections.<br><br>A care plan, dated 2/16/11, | F0282 | It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done:<br><br>The corrective action taken for the residents found to have been affected by the deficient practice was:<br><br>**Res. E has been provided with cloth briefs. Res. F's Ferrouse Sulfate was restarted on 3/28/11. Peri care was provided to Res. E. Resident was interviewed and stated she waited approximately 1 hour for staff to provide care. Staff involved have been counseled and educated on promptly responding to resident needs.**<br><br>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:<br>**Residents with an order for cloth briefs have been observed to ensure they are using cloth briefs. Full facility review of all Medication Records was completed to ensure that there were no other transcription errors. Interviewable residents were asked if they had any issues related to timeliness of care and rounds on non-interviewable residents were also made. No other issues were identified** | 04/11/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155218 | A. BUILDING _____ B. WING _____ | 03/29/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| REGENCY PLACE OF DYER | 2300 GREAT LAKES DRIVE DYER, IN46311 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| | indicated "Urinary elimination, altered pattern r/t (related to) indwelling catheter potential...infection...Approach. ..Position drainage bag below bladder level. Do not let bag or tubing touch floor..."<br><br>Resident #F was observed on 3/28/11 at 12:50 p.m., sitting in the East unit dining room. The resident's catheter tubing was observed under the wheelchair touching the floor.<br><br>Resident #F was observed on 3/28/11 at 12:52 p.m., with the Corporate Nurse Consultant present, with the catheter tubing touching the floor. The Corporate Nurse Consultant adjusted the catheter tubing so it was not touching the floor.<br><br>B) Resident #F's physician's | | **through this process.**<br><br>The measures put into place and systemic change made to ensure the deficient practice does not recur is:<br><br>**Nursing staff was educated by the DNS on using cloth briefs when ordered and following the plan of care. Licensed staff have been educated by the DNS on correctly transcribing orders to the resident medication administration record. Nursing staff has been educated by the DNS and ED related to timely call light response and provision of care at the time of need.**<br><br>To ensure the deficient practice does not recur, the monitoring system established is:<br><br>**A Performance Improvement tool has been developed that will monitor residents for the proper use of cloth briefs according to the plan of care. An additional Performance Improvement indicator has been established which evaluates compliance with transcribing physician orders** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | orders recapitulation, dated 3/11, indicated "ferrous sulfate...325 mg (milligram) tablet po (orally) give 1 tab (tablet) twice a day. 2/28/11 hold until occult stools collected."<br><br>Resident #F's MAR (medication administration record), dated 3/11, indicated the stools for the occult blood had been collected and the order was discontinued after the 3/17/11 stool specimen had been obtained. The MAR indicated the ferrous sulfate was still being held.<br><br>During an interview on 3/28/11 at 3:30 p.m., the Administrator indicated the physician wanted the ferrous sulfate resumed.<br><br>This deficiency was cited on 12/28/10 and | | **to the resident medication administration record. The DNS or Designee will complete PI tools weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI committee for further review until 100% compliance is achieved. A Performance Improvement tool has been developed that evaluates timely provision of care. DNS or Designee will complete PI tool weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI committee for further review until 100% compliance is achieved.** | |

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| | 03/03/11. The Facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>This Federal tag relates to complaints IN00083771 and IN00085845.<br><br>3.1-35(g)(2) | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F0282 SS=D | | F0282 | It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done:<br><br>The corrective action taken for the residents found to have been affected by the deficient practice was:<br><br>**Res. E has been provided with cloth briefs. Res. F's Ferrouse Sulfate was restarted on 3/28/11. Peri care was provided to Res. E. Resident was interviewed and stated she waited approximately 1 hour for staff to provide care. Staff involved have been counseled and educated on promptly responding to resident needs.**<br><br>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:<br>**Residents with an order for cloth briefs have been observed to ensure they are using cloth briefs. Full facility review of all Medication Records was completed to ensure that there were no other transcription errors. Interviewable residents were asked if they had any issues related to timeliness of care and rounds on non-interviewable residents were also made. No other issues were identified** | 04/11/2011 |

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| | | | **through this process.**<br><br>The measures put into place and systemic change made to ensure the deficient practice does not recur is:<br><br>**Nursing staff was educated by the DNS on using cloth briefs when ordered and following the plan of care. Licensed staff have been educated by the DNS on correctly transcribing orders to the resident medication administration record. Nursing staff has been educated by the DNS and ED related to timely call light response and provision of care at the time of need.**<br><br>To ensure the deficient practice does not recur, the monitoring system established is:<br><br>**A Performance Improvement tool has been developed that will monitor residents for the proper use of cloth briefs according to the plan of care. An additional Performance Improvement indicator has been established which evaluates compliance with transcribing physician orders** | |

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| | | | **to the resident medication administration record. The DNS or Designee will complete PI tools weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI committee for further review until 100% compliance is achieved. A Performance Improvement tool has been developed that evaluates timely provision of care. DNS or Designee will complete PI tool weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI committee for further review until 100% compliance is achieved.** | |

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| F0312 SS=D | Based on observation, interview, and record review, the facility failed to ensure a resident received necessary services to maintain good personal hygiene, related to leaving a resident lying in bowel movement for a long period of time for 1 of 10 residents who required assistance for toileting in a sample of 11. (Resident #E)<br><br>Findings include:<br><br>During an interview on 03/28/11 at 11:42 a.m., Resident #E indicated she had been waiting an hour to have her brief changed. She indicated CNA #1 came in and answered her call light and she told the CNA she had been incontinent. She indicated CNA #1 turned off the call light and told her she was busy with another resident and another CNA had been assigned to the Resident. She indicated she would tell the Nurse. Resident #E indicated LPN #3 came into the room and she informed the LPN she had been incontinent of bowel movement and the LPN told her she would tell the CNA assigned to her.<br><br>During an interview on 03/28/11 at 11:45 a.m., LPN #3 indicated the resident had told her she had been incontinent of bowel movement. LPN #3 indicated she had not | F0312 | It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done:<br><br>The corrective action taken for the residents found to have been affected by the deficient practice was:<br><br>**Peri care was provided to the Res. E. Resident was interviewed and stated she waited approximately 1 hour for staff to provide care. Staff involved have been counseled and educated on promptly responding to resident needs.**<br><br>The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **Interviewable residents were asked if they had any issues related to timeliness of care and rounds on non-interviewable residents were also made. No other issues were identified through this process.**<br><br>The measures put into place and systemic change made to ensure the deficient practice does not recur is:<br><br>**Nursing staff has been educated by** | 04/11/2011 |

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| | informed the Resident's CNA because the CNA was on break. She indicated she would go tell the CNA now.<br><br>During an interview on 03/28/11 at 11:50 a.m., CNA #2 indicated she was assigned to Resident #E. She indicated she had returned from a 30 minute lunch break at 11:20 a.m. She indicated she was just informed the resident needed some help.<br><br>During an interview on 03/28/11 at 11:53 a.m., CNA #2 indicate she had last checked on the resident around 8 a.m. when she picked up the resident's breakfast tray.<br><br>During an observation on 03/28/11 at 11:53 a.m., CNA #2 entered Resident #E's room to provide incontinence care to the resident. The Resident was observed to have been incontinent of soft bowel movement. The bowel movement had dried on the resident's buttocks. Upon interview of the CNA #2 during the observation, she indicated part of the bowel movement had dried on the resident's skin. CNA #2 then washed the area several times to remove the dried bowel movement. The resident's buttocks was red and excoriated and there was a superficial open area on the posterior left thigh was approximately the size of a | | **the DNS and ED related to timely call light response and provision of care at the time of need. Clinical Competencies were completed with C.N.A.'s related to providing incontinence care.**<br><br>To ensure the deficient practice does not recur, the monitoring system established is:<br><br>**A Performance Improvement tool has been developed that evaluates timely provision of care. DNS or Designee will complete PI tool weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI committee for further review until 100% compliance is achieved.** | |

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dime, round in shape and the area surrounding the open area was pink. During an interview at the time of the observation, CNA #2 indicated the skin was red and excoriated on the Resident's buttocks. She indicated the area on the left posterior thigh was opened.

During an interview on 03/28/11 after the incontinence care had been completed, the Resident indicated she was uncomfortable laying in the bowel movement.

During an interview on 03/28/11 at 12:05 p.m., LPN #3 indicated the Resident had told her about being incontinent of bowel movement around 11:20 a.m. or 11:30 a.m. She indicated the other CNA's on the unit were all busy and she was on the phone with a family member so she could not take care of resident when she requested help.

During an interview on 03/28/11 at 12:15 p.m., CNA #1 indicated the resident had told her she had been incontinent of bowel movement. She indicated she was getting ready to give another resident a shower, but answered Resident #E's call light. She indicated she had turned the call light off and left the room and told the nurse the resident had been incontinent and needed help. She indicated she did not remember

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what time she answered the resident's call light.

Resident #E's record was reviewed on 03/28/11 at 12:10 p.m. The Resident's diagnoses included, but were not limited to, hypertension and osteoarthritis.

The Annual Minimum Data Set Assessment, dated 01/18/11, indicated the resident was cognitively intact with a score of 15, required extensive assistance for toileting, bed mobility, and personal hygiene, and was frequently incontinent of bowel (two or more episodes).

A care plan, dated 03/24/11, indicated the resident was at risk for impaired skin integrity. The approaches indicated, "1. Keep skin clean & (and) dry..."

A professional resource, titled, "Indiana State Department of Health Division of Long Term Care Nurse Aide Training Program", dated 07/98, page 60, indicated, "...3. Incontinence...a. to meet the needs of the incontinent resident the CNA must: 1) respond to call light immediately. 2) Check resident often for wetness and soiling. Provide frequent perineal care and skin care..."

This federal tag relates to complaint

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| | number IN00085845.<br><br>3.1-38(a)(3)(A) | | | |

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| F0315 SS=D | Based on observation, record review, and interview, the facility failed to ensure a Resident with an indwelling catheter had the catheter tubing positioned to prevent infection for 1 of 5 residents reviewed with catheters in a sample of 11. (Resident #F)<br><br>Findings Include:<br><br>1. During the initial tour on 3/28/11 at 10:15 a.m., with the SDC (Staff Development Coordinator) present, Resident #F was observed sitting in her wheelchair in her room. The resident's indwelling catheter tubing was on the floor under the wheelchair. The SDC applied gloves and adjusted the catheter tubing so it was not touching the floor. The SDC indicated the resident had a | F0315 | It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done:<br><br>The corrective action taken for the residents found to have been affected by the deficient practice was:<br><br>**Res. F's Foley has been secured in position and is off the ground.**<br><br>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:<br><br>**Residents with foley catheters were observed to ensure that they were receiving appropriate treatment and services to prevent urinary tract infections. Appropriate interventions were implemented to ensure tubing was secure.**<br><br>The measures put into place and systemic change made to ensure the deficient practice does not recur is:<br><br>**Nursing staff was educated by the DNS on techniques for securing foley tubing.** | 04/11/2011 |

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| | history of urinary tract infections.<br><br>Resident #F's record was reviewed on 3/28/11 at 11:50 a.m. Resident #F's diagnoses included, but were not limited to, urinary tract infection, congestive heart failure, anemia, and arthritis.<br><br>A "Temporary Problems" care plan, dated 3/20/11, indicated "UTI (urinary tract infection) - T (temperature) 101..."<br><br>A care plan, dated 2/16/11, indicated "Urinary elimination, altered pattern r/t (related to) indwelling catheter potential...infection...Approach. ..Position drainage bag below bladder level. Do not let bag or tubing touch floor..." | | To ensure the deficient practice does not recur, the monitoring system established is:<br><br>**A Performance Improvement tool has been developed that will monitor residents with foley catheters to ensure that the tubing is correctly secured. The DNS or Designee will complete PI tool weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI committee for further review until 100% compliance is achieved.** | |

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| | Resident #F was observed on 3/28/11 at 12:50 p.m., sitting in the East unit dining room. The resident's catheter tubing was observed under the wheelchair touching the floor.<br><br>Resident #F was observed on 3/28/11 at 12:52 p.m., with the Corporate Nurse Consultant present, with the catheter tubing touching the floor. The Corporate Nurse Consultant adjusted the catheter tubing so it was not touching the floor.<br><br>This deficiency was cited on 12/28/10 and 03/03/11. The Facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>This Federal tag relates to complaints IN00083771 and IN00085845.<br><br>3.1-41(a)(1)<br>3.1-41(a)(2) | | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155218 | A. BUILDING _____ B. WING _____ | 03/29/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F0315 SS=D | | F0315 | It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done:<br><br>The corrective action taken for the residents found to have been affected by the deficient practice was:<br><br>**Res. F's Foley has been secured in position and is off the ground.**<br><br>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:<br><br>**Residents with foley catheters were observed to ensure that they were receiving appropriate treatment and services to prevent urinary tract infections. Appropriate interventions were implemented to ensure tubing was secure.**<br><br>The measures put into place and systemic change made to ensure the deficient practice does not recur is:<br><br>**Nursing staff was educated by the DNS on techniques for securing foley tubing.** | 04/11/2011 |

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| | | | To ensure the deficient practice does not recur, the monitoring system established is:<br><br>**A Performance Improvement tool has been developed that will monitor residents with foley catheters to ensure that the tubing is correctly secured. The DNS or Designee will complete PI tool weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI committee for further review until 100% compliance is achieved.** | |

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| F0441 SS=D | Based on observation and interview, and interview, the facility failed to ensure a sanitary environment to help prevent the development and transmission of disease and infection related to hand washing and changing gloves during and after contact with residents for 2 of 4 observations of care for 2 residents in a sample of 11. (Residents #E and #F, CNA #2 and Staff Development Coordinator).<br><br>Findings include:<br><br>1) During an observation on 03/28/11 at 11:53 a.m., CNA #2 entered Resident #E's room to provide incontinence care to the resident. The CNA applied gloves and removed the resident's brief. The Resident was observed to have been incontinent of soft bowel movement. The CNA used disposable cloths to wash the resident skin of the bowel movement. The resident's buttocks was red and excoriated and there was a superficial open area on the posterior left thigh. The CNA then applied a barrier cream to the resident's buttocks and upper posterior thighs without changing gloves and washing hands. The CNA then changed her gloves and asked the Resident to turn onto her back. The CNA then provided peri-care and applied barrier cream to the resident's groin without changing gloves and washing her | F0441 | It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done:<br><br>The corrective action taken for the residents found to have been affected by the deficient practice was:<br><br>**There has been no adverse affect noted to Res. E related to the noted provision of incontinence care or to Res. F related to the failure to wash hands prior to exiting the room.**<br><br>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:<br><br>**Resident rounds were completed to ensure that staff were utilizing gloves appropriately, there were no further incidence of catheter tubing touching the floor, and handwashing practices were completed per facility policy. Immediate education with the staff was provided as indicated.**<br><br>The measures put into place and systemic change made to ensure the deficient practice does not recur is: | 04/11/2011 |

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| | hands.<br><br>During an interview on 03/28/11 at 1:45 p.m., CNA #2 indicated hands were to be washed before and after care. She indicated she was suppose to wash her hands during care if they needed it.<br><br>During an interview on 03/28/11 at 1:50 p.m., RN #4 indicated hand washing should be done before and after care. She indicated she was unsure of the facility's policy. She indicated the gloves need to be changed before going to different parts of the peri-anal area. She indicated hands should be washed between washing the resident and applying barrier cream. | | **Facility staff was educated by the DNS and ED related to infection control practices to include hand washing technique and the proper use of gloves.**<br><br>To ensure the deficient practice does not recur, the monitoring system established is:<br><br>**A Performance Improvement tool has been developed that evaluates hand washing technique and glove use. DNS or Designee will complete PI tool weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI committee for further review until 100% compliance is achieved.** | |

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| F0441 SS=D | 2. During the initial tour on 3/28/11 at 10:15 a.m., with the SDC (Staff Development Coordinator) present, Resident #F was observed sitting in her wheelchair in her room. The SDC indicated Resident #F had a history of urinary tract infections. The resident's indwelling catheter tubing was on the floor under the wheelchair. The SDC applied gloves and adjusted the catheter tubing so it was not touching the floor. The SDC removed her gloves and left the room without washing her hands.<br><br>During an interview on 3/28/11 at 2:40 p.m., the SDC indicated she should have washed her hands before leaving Resident #F's room. | F0441 | It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done:<br><br>The corrective action taken for the residents found to have been affected by the deficient practice was:<br><br>**There has been no adverse affect noted to Res. E related to the noted provision of incontinence care or to Res. F related to the failure to wash hands prior to exiting the room.**<br><br>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:<br><br>**Resident rounds were completed to ensure that staff were utilizing gloves appropriately, there were no further incidence of catheter tubing touching the floor, and handwashing practices were completed per facility policy. Immediate education with the staff was provided as indicated.**<br><br>The measures put into place and systemic change made to ensure the deficient practice does not recur is: | 04/11/2011 |

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| | A facility policy, dated 10/09, titled, "Hand Hygiene/Hand washing", received from the Administrator as current, indicated, "...Hand hygiene is to be performed:...After touching blood, body fluids, secretions,excretions and contaminated items, whether or not gloves are worn; Between tasks and procedures on the same resident when contaminated with body fluids to prevent cross-contamination of different body sites...After handling soiled equipment or utensils...Intermittently after gloves are removed, between resident contacts..."<br><br>This federal tag relates to complaint number IN00085845.<br><br>3.1-18(l) | | **Facility staff was educated by the DNS and ED related to infection control practices to include hand washing technique and the proper use of gloves.**<br><br>To ensure the deficient practice does not recur, the monitoring system established is:<br><br>**A Performance Improvement tool has been developed that evaluates hand washing technique and glove use. DNS or Designee will complete PI tool weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI committee for further review until 100% compliance is achieved.** | |